STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. Building B. Wing	07/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laguna Honda Hospital & Rehabilitation Ctr D/P Snf	375 Laguna Honda Blvd. San Francisco, CA 94116

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect Resident 1 of a significant medication error when LVN1 administered a non-prescribed medication ([MEDICATION(S)]-medication used for seizures) to Resident 1, which resulted in hospitalization . Findings: A review of clinical record on 3/18/20 for Resident 1 indicated that Resident 1 was a [AGE] year-old male with a past medical history of [MEDICAL RECORD OR PHYSICIAN ORDER] . A review of a physician progress notes [MEDICAL RECORD OR PHYSICIAN ORDER] . around 9:30 a.m . Patient is not responding his resisting to the exam by keeping his arms inward at crotch. Patient also resisting opening the eyelid not following any commands sometimes he moans. During an interview on 03/24/21 at 1:30 PM Nurse Manager 1 stated Resident 1 had a change of condition on 12/18/20. Resident 1 was drowsy, fatigued, and non-responsive, then transferred to the hospital. A review on 3/18/21 of the Comprehensive Drug Test for Resident 1 indicated a positive test result for [MEDICATION(S)] (medication usually used for seizures). The test result indicated that Resident 1 had [MEDICATION(S)] in his urine. The test was collected on 12/18/20 at 1:24 PM. During an interview on 3/18/21 at 2:45 PM Toxicologist 1 stated that in her opinion, the sample tested confirmed Resident 1 had been administered [MEDICATION(S)]. She believed that, based on the data, Resident 1 had [MEDICATION(S)] in his system. During an interview on 03/22/21 at 11:15 AM Nurse Manager 2 stated LVN 1 was alerted by the facility computer system with the following alert No administrative orders for [MEDICATION(S)] 250mg/5ml oral solution were found for this patient . Nurse Manager 2 said that this alert meant that LVN 1 had scanned and bypassed the alert for Resident 1. LVN 1 overrode the alert. Nurse Manager 2 also stated that the alert was supposed to warn LVN 1 that he had scanned the wrong medication for Resident 1. A review of the clinical record indicated Resident 1 did not have prescriber orders for [MEDICATION(S)]. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0760 Level of Harm - Actual harm Residents Affected - Few	A review on 3/19/21 of the [MEDICATION(S)] SCANNING ALERT indicated that on 12/17/20 there was an alert that indicated No administrable order with [MEDICATION(S)] 250mg/5 ml oral solution were found for this patient [Resident 1] . The alert was triggered by LVN 1 at 7:16 PM on 12/17/20. The next day Resident 1 was drowsy, fatigued and non-responsive then admitted to the hospital. During an interview on 3/23/21 at 3:40 PM, LVN 1 stated he was responsible for Resident 1, and he did not recall the scanning alert on 12/17/20. LVN 1 did state that a resident shared a room with Resident 1 that was on [MEDICATION(S)]. LVN 1 also stated that he was not sure what had happened to Resident 1 during the next day when Resident 1 was drowsy, fatigued, and difficult to arouse. A review on 3/18/21 of Lexicomp Online, a nationally recognized drug information resource, indicated for [MEDICATION(S)] the indication for use was for seizures and the most common side effects were ataxia (loss of control of body movement), dizziness, drowsiness, and fatigue. During an interview on 03/24/21 at 1:30 PM Nurse Manager 1 stated Resident 1 appeared to have the drowsiness, fatigue, and non-responsive on 12/18/20. She also stated that LVN 2 was at the bedside and could better describe Resident 1 at that time. During an interview on 4/20/21 at 1:33 PM, LVN 2 stated that Resident 1 was definitely not himself on 12/18/20 and he had significant concerns regarding Resident 1 not being responsive and being sedated. LVN 2 also stated that she then called the physician. During an interview on 4/6/21 at 2:00 PM, Physician 1 stated that it was possible that Resident 1's change of condition was due to the [MEDICATION(S)]. She also stated that Resident 1 had chronic renal failure. She agreed that for a resident with chronic renal failure when given [MEDICATION(S)] the effects could be exaggerated. A review on 4/6/21 of Resident 1's progress notes dated 12/21/20 and signed by Physician 1 indicated Patient had episode of altered mental status December 18, 2020 .I received in my inbox the result showing [MEDICATION(S)] .Reviewing patient's medication list I can see .there is no [MEDICATION(S)] . Patient has end-stage renal disease so even if he received small dose of [MEDICATION(S)] that can persist in the system for long time . During an interview on 4/20/21 at 11:00 AM, Physician 2 stated that she was the physician that took care of Resident 1 at the hospital. Physician 2 also stated that the [MEDICATION(S)] definitely could have contributed to Resident 1's drowsiness and non-responsiveness, which resulted in hospitalization . Physician 2 said that Resident 1 had chronic renal failure and it could have taken days before the drug cleared Resident 1's system. During an interview on 4/27/21 at 10:00 AM, Hospital Pharmacist 2 stated that he was specialized in pharmacokinetics (study of what the body does to the drug). He said that the effects of [MEDICATION(S)] would peak within hours and the peak levels could easily last for days. He said it was definitely possible that when Resident 1 could have experienced the side effects for days. He also stated that [MEDICATION(S)] should not have been administered to Resident 1 because he had very poor renal function. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	A review of Lexicomp Online, a drug information resource, for [MEDICATION(S)] indicated that patients with severe renal dysfunction there was no appropriate maintenance dose. There was no recommended [MEDICATION(S)] dose for patients with severe renal dysfunction. Resident 1 had severe renal dysfunction.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to provide laboratory services to meet the needs of Resident 1 when the facility did not forward pertinent lab results, positive urine test for [MEDICATION(S)], to the hospital. This failure resulted in the hospital not having all the pertinent information to diagnose Resident 1's condition. Findings: A review of clinical record on 3/18/20 for Resident 1 indicated that Resident 1 was a [AGE] year-old male with a past medical history of [MEDICAL RECORD OR PHYSICIAN ORDER] . A review of a physician progress notes [MEDICAL RECORD OR PHYSICIAN ORDER] .around 9:30 a.m . Patient is not responding his resisting to the exam by keeping his arms inward at crotch. Patient also resisting opening the eyelid not following any commands sometimes he moans. During an interview on 03/24/21 at 1:30 PM Nurse Manager 1 stated Resident 1 had a change of condition on 12/18/20. Resident 1 was drowsy and fatigued and then transferred to the hospital. She also stated that it was later found that Resident 1 had a urine toxicology screen and found that Resident 1 had [MEDICATION(S)] in her system and did not have prescriber orders for [MEDICATION(S)]. During an interview on 4/20/21 at 11:00 AM Physician 2 stated that she was the physician that took care of Resident 1 at the hospital. Physician 2 also stated that during the whole hospital stay the hospital did not received information that Resident 1 had tested positive for [MEDICATION(S)], and had not been prescribed [MEDICATION(S)]. Physician 2 said that the [MEDICATION(S)] definitely could have contributed to Resident 1's drowsiness and non-responsiveness, which resulted in hospitalization . Physician 2 said that Resident 1 had chronic renal failure and the [MEDICATION(S)] could have been in Resident 1 for days. During an interview on 4/13/21 at 10:08 AM the Hospital Pharmacist stated and confirmed that the hospital had not received Resident 1's urine toxicology results that were positive for [MEDICATION(S)] during the hospital stay. The Hospital Pharmacist also stated that the hospital would not have received test results that were drawn in the facility unless the facility forwarded the test results to the hospital. The results were never forwarded to the hospital. During an interview on 4/21/21 at 9:37 AM, Nurse Manager 1 stated she was not aware that the positive urine toxicology was faxed to the hospital. She also stated that the hospital would request information to be faxed, however in this case she acknowledged that the hospital would not have known to request the positive urine toxicology test because the hospital was not aware that it had been drawn. During an interview on 4/29/21 at 2:20 PM, Quality Manager stated there was no evidence that the facility had communicated the urine toxicology test results to the hospital. She acknowledged that it was important to communicate the lab results to the hospital so they may be able to appropriately treat and diagnose Resident 1.